Correspondence

Causes of Anosmia

TO THE EDITOR: Davidson and co-workers evaluated 63 patients at their Nasal Dysfunction Clinic.[1] None of these had nasal polyps. Yet, it seems, this is a most common (if not the most common) cause of anosmia. It is easily diagnosed and frequently associated with allergic rhinitis and asthma.

Perhaps the reason none of their 63 patients had nasal polyps is that only difficult puzzling cases were referred to their clinic. Yet nasal polyps and anosmia are so common that the readers should be cognizant of this fact and search for nasal polyps before looking further for a cause of the patient's smell dysfunction.

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REFERENCE

1. Davidson TM, Jalowayski A, Murphy C, et al: Evaluation and treatment of smell dysfunction. West J Med 1987 Apr; 146:434-438

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TO THE EDITOR: I read with interest the article "Evaluation and Treatment of Smell Dysfunction" by Terence M. Davidson, MD, and colleagues in the April issue.[1]

I recently saw a patient with long-standing asthma and rhinitis in whom progressive and insidious anosmia developed which turned out to be related to a baseball-sized frontal lobe meningioma. Frontal lobe tumors have been associated with anosmia.

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REFERENCE

1. Davidson TM, Jalowayski A, Murphy C, et al: Evaluation and treatment of smell dysfunction. West J Med 1987 Apr; 146:434-438

The Plight of Public Hospitals

TO THE EDITOR: The complexities involved in delivering quality graduate training to medical students were well described by Gerbert and co-workers in their recent article.[1] Unfortunately, the unique dilemmas that public teaching hospitals are suffering in that regard were not adequately addressed. The accompanying editorial also stressed the impact of changes in funding for graduate medical education on private institutions.[2] In California, however, where public hospitals provide such functions to a very large portion of graduates, the greatest impact is on them rather than the private academic centers.

Public hospitals traditionally care for the largest number of poor patients and rely heavily on state or local governmental funding for both patient care and for educational activities. To compound the problem, private hospitals, for all the reasons described by Gerbert, are reducing the share of their resources devoted to charitable care or bad debts. Consequently, poor people are being forced out of the private institutions back to our public hospitals.

Faced with this ever increasing number of poor and uninsured patients and forced to care for them at reduced federal and state payment levels with limits on the amount of charges that can be allocated to graduate medical education places such institutions in an ever increasingly compromised position.[3,4]

Unfortunately, they do not have the option of securing larger numbers of paying patients to offset the costs of providing more care for nonpaying patients. As Gerbert so succinctly outlined for the private hospital, the public teaching hospital likewise has an even greater difficulty reducing its costs to compete with the private nonteaching hospitals. This has been an historical fact which prevails even today. Yet, as an academically affiliated health care center, we are expected to expose the graduates to the latest technological advances in medicine, to provide them with access to state-of-the-art laboratory tests, to give them opportunities for doing clinical research, to offer community-based physicians exposure to continuing education opportunities and to maintain a quality of patient care that is at least equal to community standards—all of this without placing undue additional burdens on the taxpayer.

Since care to the poor remains our primary commitment, which we morally will not and legally cannot abandon and to which our monetary resources must be primarily directed, economic stresses may increasingly jeopardize a public institution's commitment to its educational activities.

As identified in a recent Commonwealth Fund Task Force report on Academic Health Centers, one must first accept that public hospitals are not likely to obtain increased appropriations to compensate for an increased load of poor, uninsured patients.[5] Therefore, the only sources available to support this increased patient load will be redistribution of available funds away from other areas of expenditure. Two obvious areas come to mind. First, there may be a reduction in medical school faculty to staff the hospital. Second, the institution might be forced to reduce or abandon its educational functions. Neither of these should be permitted to happen. The presence of full-time medical school faculty to supervise trainees has been historically shown to assure not only an improved education for them but also has increased the quality of care given to the patients. Arguably, the care is more expensive but not necessarily more than if that same training were carried out in a private institution. Physicians in graduate training programs, regardless of the training site, are essentially performing apprenticeships, analogous to training in industry, who then become "journeymen" physicians. Apprentice programs in industry are characteristically also expensive operations. To reduce or abandon graduate training programs is also not an effective solution. Ample data have been presented supporting the contention that too many physicians are being trained. Since public hospitals in California produce the largest number of graduates, one could argue that those are the very institutions that should make reductions in their training programs. I do not agree. In my opinion, large public teaching hospitals and their clinics still remain the single best learning resource for graduate physicians. Graduates are exposed to a wide variety of patients and diseases requiring primary as well as other care, including patients similar to those seen at tertiary private institutions. To replace this wealth of patient resource in the private sector, the training programs would clearly have to decentralize their educational efforts to hospitals and ambulatory sites with a sufficient concentration of patients to assure that graduates are exposed to an adequate number of patients with a diverse spectrum of diseases. In rebuttal, smaller private institutions argue that it is not the number of patients seen but the quality